SOCIAL ISOLATION AND ISOLATION-REDUCING PROGRAMS*

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ONE of the major distinguishing social characteristics of the aged is their social isolation. Social isolation or, perhaps, social marginality, is the absence of meaningful social roles, or rolelessness.[1] The very names by which the social positions of the aged are designated imply that former role partners are not available for support, nurture, stimulation, interest-sharing, or other forms of social interaction. Terms such as widow, widower, retiree, or emeritus imply the absence of role partners. Social isolation may be thought of as socially induced sensory or stimulus deprivation.

Little is known about absolute or relative numbers of social isolates among the aged nationally nor does it make sense to guess at them. Clearly the social isolation of the aged is a well-known national phenomenon. Recently, concern was expressed in a United Nations General Assembly report on aging about the impact on the elderly of rapid urbanization and industrialization in newly developing countries, where young families are encouraged to move to cities, thereby abandoning the old in rural areas.[2] Probably the rates of isolated, aged persons will increase, largely because most of the aged are women who are usually found in more marginal positions in society than men.

It has been noted many times, but it bears repetition that the census category, "living alone," probably is not a true indicator of social isolation in the aged. Unfortunately, at this point in time there seems to be no agreement on an index of social isolation to be used to survey

*Presented in a panel, Overcoming Forced Idleness, Impoverishment, and Isolation as part of the 1973 Health Conference of the New York Academy of Medicine, *Problems of Older People: Forced Idleness, Impoverishment, Ill Health, Isolation,* held at the Academy April 30 and May 1, 1973.

the incidence of social isolation in the aged nationally. However, there seems to be an urgent need to conduct such surveys.[3]

Many factors beyond the control of any single aged person probably contribute to the social isolation of the aged. These include mandatory retirement rules with the attendant meager financial resources, reduced mobility due to physical infirmity, deaths of spouse, relatives, friends and other age peers, social and geographic mobility of offspring, and widespread prejudice against the aged.[4]

There seems ample evidence indicating that there is a relation between isolation and low morale, a concept sometimes used interchangeably with personal adjustment.[5]

By virtue of the seemingly involuntary nature of social isolation in the aged and its negative consequences, some of which will be described later in discussing my own work, there seems to be a need for policies and programs aimed directly at preventing and compensating for social isolation. Some of our research to be described also touches on the development and evaluation of such programs.

Our research, to which I shall devote most of the remainder of this paper, has focussed not only on the relation between social isolation and morale, but also on the variables of social adjustment, mental status, and cognitive functioning. Our research on social isolation was begun 17 years ago with a study in which 100 case records of the Jewish Home and Hospital for the Aged were used to identify those characteristics which differentiated residents who were transferred to a mental hospital from those who were not. Fifty residents who were transferred were compared to controls matched for age, sex, and length of residence who remained in the home. The findings showed that poor scores on a combined index of social isolation experienced prior to entering the home were related to inability to get along with staff members and other residents and sometimes resulted in transfer to a mental hospital.[6]

Given the limitations of case-record studies, a direct survey was undertaken of 100 elderly residents, two thirds of whom were women in their late 70s. One hundred consecutive admissions to the home were interviewed three times, once on admission and again at one- and two-month intervals. Data on their adjustment after six months were collected from social work case records and from interviews with recreation workers in the home.[7]

TABLE I. RANK-ORDER (RHO) CORRELATIONS BETWEEN ISOLATION, SOCIALIZATION, AND ADJUSTMENT AFTER ONE, TWO, AND SIX MONTHS OF RESIDENCE IN A HOME

Isolation and socialization	*Socialization and adjustment*								
	One month				*Two months*				*Six months adj.*
	Soc.	*Int.*	*Eval.*	*Conf.*	*Soc.*	*Int.*	*Eval.*	*Conf.*	
Adulthood	.23*	.21*	.02	.00	.22*	.23*	.04	.11	.09
Pre-entry	.27†	.16	.07	.02	.27†	.22*	.08	.13	.19*
Socialization (one month)		.51‡	.26†	.08	.79‡	.50‡	.12	.02	.32†
Socialization (two months)					—	.48‡	.10	−.04	.26†

*P < .05
†P < .01
‡P < .001

The findings in Table I show that residents who experienced isolation before entering the home had difficulty becoming socialized. The relation between socialization and isolation was greater than the relation between isolation and any of the three components of adjustment.[8] Desocialization, or inaccurate perceptions of life in the home, seemed to be an intervening factor mediating the relation between isolation experienced prior to entry and subsequent poor adjustment.[9] Early or rapid socialization, rather than socialization per se, related best to adjustment. That is, those with accurate perceptions of life in the home in the first month adjusted better than those who subsequently became socialized.[10]

Four patterns of isolation were differentiated.[10] They were: nonisolation, old-age nonisolation, involuntary isolation, and voluntary isolation. These patterns were studied in relation to socialization. Table II shows that all patterns of isolation had negative effects on socialization, in contrast to nonisolation. The score differences between nonisolates and the group next in line were greater than between any two types of isolates.[12]

This led to the suspicion that there were two, or possibly more, "syndromes" related to similarily maladjusted behavior found among the residents: one was mental disorder, which probably resulted in

TABLE II. RELATION BETWEEN PATTERN OF ISOLATION AND SOCIALIZATION AT TWO MONTHS

Isolation pattern				*Socialization at two months*
	Adulthood	*Pre-entry*	*N*	*% above median*
Nonisolate	Not isolate	Not isolate	31	77
Early isolate	Isolate	Not isolate	10	50
Involuntary isolate	Not isolate	Isolate	14	36
Voluntary isolate	Isolate	Isolate	45	29

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hospitalization; the other has since been termed the isolation-desocialization syndrome, for want of a better name. The isolation-desocialization syndrome is a process that may look like this: An old person in the community becomes isolated, then desocialized. He enters a home for the aged or some other such institution. He misunderstands the norms and makes some social blunders after entry. Others single him out, perhaps as a "troublemaker," and avoid him. He then becomes resentful and alienated. Finally, he deviates further from the norms by becoming involved in overt conflict with members of the staff or other residents. Presumably, a history of social isolation would not be as great a handicap to an old person who remained in the community as it is to one who is relocated and must adjust socially. However, also presumably, the effects of social isolation may be remediable, whereas those resulting from mental disorders of the senium probably are hopeless.

It was not clear from our early studies, just described, whether some of the maladjusted behavior observed was the result of the isolation-desocialization syndrome or of mental disorder, nor did we know if both isolation and maladjusted behavior resulted from mental disorder. It was our good fortune to have working with us a visiting psychiatrist, trained in Britain, who wanted to study in a nonclinical manner the relation between social isolation, mental disorder, and social adjustment in the aged. Fifty-three successive residents who had been studied two years earlier were independently evaluated by the psychiatrist, using a crude standard diagnostic form he designed to determine

TABLE III. MEAN SCORES ON WAIS SUBTESTS AND SOCIALIZATION INDEX IN WAITING-LIST, NEWCOMER, AND OLDTIMER GROUPS*

Mean WAIS scores	*Waiting-list group*	*Newcomers*	*Oldtimers*
WAIS information	13.10	15.00	13.55
WAIS similarities	5.95	7.40	6.35
WAIS comprehension	13.50	15.65	16.45
WAIS total	32.55	38.05	36.35
Socialization index	10.10	18.50	20.30

*χ^2 values were computed for differences found among groups for all tests. They were as follows:

WAIS information:	$\chi^2 = 2.73$	$p < .10$
WAIS similarities:	$\chi^2 = 3.16$	$p < .10$
WAIS comprehension:	$\chi^2 = 6.13$	$p < .02$
WAIS total:	$\chi^2 = 9.57$	$p < .01$
Socialization index:	$\chi^2 = 64.56$	$p < .001$

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the presence or absence of organic or functional mental disorder. This measure was designed to exclude data on early social isolation or social adjustment and was based largely on current cognitive functioning. Findings showed no relation between social isolation and mental disorder.[13]

The next series of studies which were conducted were designed to determine if increased social interaction, in the form of actual admission to the home, improved social adjustment and cognitive functioning. Using whatever standard measures were available for social performance and which could be administered to the aged both in and out of the home, we studied persons on a waiting list, newcomers, and oldtimers to determine the relation between isolation, socialization, mental state, and cognitive functioning, both on admission to and after one year of residence at the home.[14]

The distribution of means on the Wechsler Adult Intelligence Scale (WAIS) test scores for waiting-list subjects, newcomers, and oldtimers are seen in Table III. They show that on all the WAIS subtests means were higher for the resident groups than for the waiting-list group. The newcomers' scores on WAIS total and on all WAIS subtests, with the exception of WAIS comprehension, were higher than those of both

TABLE IV. MEAN SCORES ON WAIS SUBTESTS AND SOCIALIZATION INDEX FOR INTERVIEWS NO. 1 AND 2 FOR SURVIVORS

Subtest	*Waiting list*		*Newcomers*		*Oldtimers*	
	Time 1	*Time 2*	*Time 1*	*Time 2*	*Time 1*	*Time 2*
WAIS information	13.1	13.6	17.1	16.5	14.0	12.8
WAIS similarities	6.6	8.1	8.6	9.4	6.9	4.8
WAIS comprehension	13.9	14.9	17.1	16.5	17.0	14.1
WAIS total	33.7	36.6	42.8	42.5	37.9	31.6
Socialization index	10.1	22.8	18.5	22.8	20.3	22.9

N = 40

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the waiting-list group and the oldtimers. Differences in mean total WAIS scores were significant at the 0.01 level across groups. Newcomers seemed to perform best, possibly because they were in the midst of being socialized.[15] Oldtimers appeared to have reached a performance plateau and waiting-list persons performed worst of all, perhaps because they were the most socially isolated and deprived of cognitive experiences and stimulation.[16]

Residents as a group obtained markedly higher socialization scores than people on the waiting list, which came as no surprise, since they knew more about life in the home.[17] The waiting-list group, despite some exposure to the admission interview and intake procedure, was largely unaware of norms and practices in the home.

To determine if waiting-list persons' scores actually increased after admission, a one-year follow-up study was undertaken. Forty survivors of the waiting list, newcomers, and oldtimers were seen again. As may be seen in Table IV, waiting-list persons improved when they became newcomers, indicating a "spill-over" effect of socialization or, perhaps, increased motivation to perform on tests. Oldtimers and former newcomers, however, seemed to deteriorate. Perhaps, had the home continued to offer them salient learning experiences, this would not have occurred. From these studies, it was concluded that isolation reduced social and other performances while interaction stimulated good performance.

At one point in our series of studies, we looked for the brighter side of social isolation if there was one. We thought isolation may well have some salutary personality effects, possibly resulting in attitudinal independence, as in the "rugged individualist" or "old codger" who would fight any restraints. This was not found to be the case; in fact, the opposite was found to be true.[18]

From our past research as well as that of others we tentatively concluded that the involuntary nature of social isolation and its attendant negative consequences indicate a great need for social policies, practices, and programs to combat isolation. It seems hardly necessary to repeat this idea, yet its repetition has not seemed to provoke any major programmatic efforts in this direction. This may be because the problem of social isolation of the aged seems insurmountable, because some of the solutions seem so simple, though expensive, that they have no news value,[19] or because those community programs which have been aimed specifically at the aged have not been evaluated systematically and it is assumed they have not reduced isolation or improved mental state, morale, social adjustment, cognitive functioning, or any other process indicative of maladaptation in the aged.[20] Therefore, we were led to develop several experimental resocialization programs aimed at the isolated aged in the community and to develop assessment techniques to evaluate their impact systematically.

The first of these experimental programs to be discussed is the Teachers College (Columbia University) Friendly Visitor Program (TC-FVP) which we have been conducting over the past four years. The TC-FVP was developed by several groups of graduate students and some faculty members in a training program in gerontology who ferreted out isolated aged persons in the Morningside Heights health catchment area—a high-crime-rate, densely populated, apartment-building section of New York City surrounding Columbia University. Pilot research was conducted during the first two years to determine if it was possible to locate isolated elderly persons, if they would cooperate in a study, and if measures could be developed to assess as unobtrusively as possible the behavior of old persons residing in their own homes.[21]

The Friendly Visitor Program was designed as a resocialization program to reduce social isolation, with a built-in systematic evaluation study to determine its impact on the behavior patterns of isolated elderly people. Visits were made to 24 New York City residents whose mean

age was 77. The sample consisted of an experimental and a control group. Pre- and post-testing visits collected baseline data on measures of isolation, social adjustment, cognitive functioning, mental state, and self-report of health. The major procedure was an hour-long structured visit made every two weeks for six months by one of five pairs of trained visitors. Only one pair visited the control group for two sessions comparable to pre- and post-testing in the experimental group.

A running assessment on the experimental group was done in order to record observations over time, as well as to study the effects of visiting over time. Extensive interview and assessment schedules were developed for data-gathering purposes, As noted earlier, for two years before the present study was begun, we conducted pilot research using qualitative measures. The findings of the earlier pilot study had indicated a marked improvement in social skills, grooming, and apartment upkeep in the elderly visited, as well as an expressed desire to have the visits continue. We expected the newly developed and more quantitative measures to yield similar as well as highly significant results. Three community volunteers continue to visit six elderly persons studied in the pilot research every other week. Unfortunately, we were not able to get funds to develop a backup visiting service to allow us to continue to follow all of the aged persons in the study on a permanent basis. However, the elderly visitees were warned about the possibility of termination of visits when visits to them were first begun.

Preliminary analysis of results show that past-month isolation scores, which were very low, indicating extreme isolation in both groups, were not changed by the friendly visitors. That is, those visited frequently did not become more social as a result of the visits. Nor did the old people in the control group do so. Both the experimental and control groups remained socially isolated over time; however, the experimental group continued to receive visitors from the Friendly Visitor Program for the duration of the study. And now the six-month follow-up data indicate that those visited do become more socially involved with time.

Personal grooming was initially better in the experimental group than in the control group; however, both groups remained constant in their personal-grooming rating. On the other hand, apartment upkeep improved in the experimental group only. Neither group complained initially of many physical ailments; however, the number of complaints about ailments went up in the control group. Mental state improved in

TABLE V. A COMPARISON OF SELECTED SCORES OF PERSONS IN AND NOT IN THE TEACHERS COLLEGE FRIENDLY VISITOR PROGRAM

	Persons in the Friendly Visitor Program (experimental group)	*Persons not in the Friendly Visitor Program (control group)*
Mean age:	76	79
Past month isolation score:		
	1st visit N = 12	1st visit N = 12
	$\overline{X} = 1.3$	$\overline{X} = 2.4$
	12th visit N = 12	12th visit N = 12
	$\overline{X} = 1.3$	$\overline{X} = 2.3$
Grooming (rating of neat and clean):		
	1st visit = 92%	54%
	12th visit = 92%	54%
Apartment (rating of neat and clean):		
	1st visit = 63%	54%
	12th visit = 82%	54%
Number of ailments reported:		
	1st visit = 1.9	2.7
	12th visit = 1.9	3.1
Number in community on six-month follow-up:		
	8 of 12	5 of 12

TABLE VI. FREQUENCY DISTRIBUTION AND MEAN SCORES OF MENTAL STATUS QUESTIONNAIRE AND MENTAL STATUS SCHEDULE FOR EXPERIMENTAL GROUP ON VISIT NO. 1 (T^1) AND VISIT NO. 12 (T^2)*

ID No.	*Mental Status Questionnaire* T^1	T^2	*Mental Status Schedule* T^1	T^2	*MSS total scores* Σ *12 visits*
14	10	10	0	0	2
15	10	10	2	2	14
16	4	2	7	5	48
18	8	7	4	6	66
19		7	7	4	47
20	9	10	3	0	35
21	10	10	3	0	7
22	5	8	5	1	26
23	10	10	1	1	5
24	10	10	2	0	3
25	8	8	0	0	0
	N = 10	N = 11	N = 11	N = 11	N = 11
Mean	8.4	8.4	3.1	1.7	23.0

*$r = .66$, $p < .05$

the experimental group but remained constant in the control group. The six-month follow-up study found most of the experimental group still in the community (eight of 12) while most of the control group was institutionalized (seven of 12).

Some results showing the TC-FVP impact are shown in Table V. A major result of the study was the development of assessment techniques that could be used to evaluate systematically elderly community residents. Ninety items of the Mental Status System (MSS) to measure functional disorder, devised by Spitzer,[22] and the 10-item Mental Status Questionnaire (MSQ) to measure organic impairment, devised by Goldfarb,[23] were given.

Using these measures, it was found that when there was organic impairment there was usually functional impairment. But when there was functional impairment, there was not necessarily organic impairment. Organic impairment seemed to throw the older person in the community more out of step with his environment than did functional impairment, as some of the cases will illustrate.

Table VI is included here to show the correspondence of MSQ and MSS scores. A high MSQ usually corresponds to few symptoms, that is, a low MSS. Table VI also shows the stability of MSQ scores over a six-month period, while MSS scores show a drop in mean scores, indicating that symptoms of functional mental disorders diminish with prolonged friendly visiting.

Case Histories

Most of the remainder of this paper is devoted to a discussion of five cases. Each case illustrates how an elderly person with or without a mental disorder copes with his social environment and social problems. In all instances these individuals were socially isolated. In some cases the problems seem to be overwhelming, in others not. The case reports to be read were not written for the purposes to which they are now being put. However, they can be used as examples of ways in which problems might lead to deterioration even if the older person is mentally sound at time of testing.

The case of Mr. C. is that of a mentally normal individual who would be expected to deteriorate with time if some assistance in solving his social problems is not forthcoming.

Case No. 14. Low MSS (14) Count and high MSQ (10), with other

problems. Mr. C., age 66, is a hemiplegic and victim of weak spells caused by high blood pressure. He reported that he had been mugged 21 times on the street when he had gone out to do errands. He will not use food stamps, which he claims "make you a target for muggers." Nor will he leave his room on days that the Social Security and welfare checks come, for fear of muggers in the hallways of the building in which he lives.

Mr. C. made no effort to "dress up" his room in a run-down, single-occupancy hotel on the Upper West Side, stating clearly that he wanted the visitors to see it "like it is!" Yet he did make an effort to improve it somewhat for the succeeding visits.

Mr. C. is a college graduate who worked as a proof-reader in an editor's office of a newspaper. He would probably try to better himself and his surroundings if it were not for his sister who is adamant about not moving from this welfare hotel where she has lived for 17 years. He told the visitors that "even the police told us that we were asking for trouble by continuing to live there." Mr. C. has one suit of clothes; "the rest were stolen from his room." He always appeared to be unshaven and with no apparent interest in his grooming. He does not keep money in his room because "the addicts and pushers in my building are so desperate for money that they'd kill their victim to get it." He does not use the bathroom in his hallway after 10 p.m. because of "the risk of finding a drug addict there, usually alive—occasionally dying or dead of an overdose."

From the first visit it was evident to the visitors that Mr. C. enjoyed the visits and wanted some one to converse with. He is well-informed on social issues: e.g., busing, pollution, social security, and politics. He speaks of his "organizational days" when he was thrown out of a club because he tried to "get the leaders ousted because they were no good." He speaks of his happy childhood in a little Pennsylvania town where skiing and tobogganing were seasonal sports.

Mr. C. was interested enough to ask "how the research project was going," and seemed glad that the visitors would share with him some of their "friendly visiting" findings. This reminded him (and he reminded the visitors) that the visits would soon be over. There were evident signs of disappointment in his voice that the visits had to come to an end. (Shortly after the last visit a pair of community visitors took over and are continuing to visit Mr. C. and his sister, Mrs. G.)

Discussion. Despite good mental health, Mr. C. is so heavily burdened he may well deteriorate because of social problems.

The remainder of the cases indicate the problems faced by isolated, more mentally frail individuals.

Case No. 15, Low MSQ (5) and high MSS (47), with other problems. Mrs. D., age 83, was not intact enough mentally to cope with taking the numerous medications prescribed for her. She received three negative ratings on a 12-item physical health observation schedule. She had swollen legs, swollen ankles, and a bandaged wrist. She claimed she only visited a "foot doctor" and never saw a medical doctor. She took many pills. Her vials of medications were unclearly marked for Rx, dates, and dosages. Of the assortment of some 12 vials, only two were labeled but their dates were smeared. She lacked knowledge of what the pills were. On the only two legible labels the names Digoxin and Hydrodiuril were found, both of which require a degree of intact intellect for proper dosage and usage.

Case No. 16. Low MSQ (4) and high MSS (48), with other problems. This case is similar to that of Mrs. D. Mrs. G., an 82-year-old woman, calls "home" a single-room occupancy in a fourth-rate hotel in upper New York City's West Side. Widowed for more than 20 years, she tries to keep in touch with her daughter, whom she says she "saw a few weeks ago" and her son who "phones or writes from Chicago." She saw her daughter's children last summer but could not remember when she saw her son's family.

On the first visit the friendly visitors found Mrs. G. quite disoriented and intermittently confused. They reported that "only her good social affect holds her in good stead." "She virtually thirsts for companionship and attention," according to the report. Her daily routine includes a great deal of sleeping in her chair. One visitor remarked, "I can't help but wonder how she she remembers where to go when she leaves her room—I do believe she'd get lost if she went outside in the community alone."

Visit No. 3 found Mrs. G. in great physicial distress. Up to now she had reported her health as good, "just problems of old age." She had an appointment with the doctor but she "couldn't remember his name." Neither did she remember that the visitors were coming that day, although they had written down the time and date of the visit. The report continues: "the help offered/available by 'the Desk' [of the hotel]

is truly a life-line." The visitor inquired at "the desk" to find out how Mrs. G. utilizes their services.

By the fourth visit Mrs. G. had seen the doctor. Although she could not recall the reason for the visit, she did remember that he had given her pills—all six to be taken at one time in the morning. She asked the visitor for water and the latter reports: "I gave her water—and saw six prescriptions—1 DIGITALIS, 1 DIGORIN, 1 RITALIN, 1 MULTI-VITAMINE and 2 I forgot." She thought she had taken the prescriptions as directed but the visitor remarked: "She's forgetful and an unreliable reporter. [She] was quite short of breath, respiration seemed rapid, ankles were edemetous, almost up to the midcalf line. She was coughing. She complained of stomach pain and nausea." During the visit Mrs. G. spoke of her disappointment in not being able to share Thanksgiving with her daughter who, she said, had "backed out."

As the visits progressed, Mrs. G. seemed to improve somewhat. Indicative of a new vitality was her remark that she was "entertaining some these days." The visitor's report read: "As we arrived, a lady was just leaving Mrs. G.'s apartment—the first time we've seen a visitor. Mrs. G. commented that she is entertaining some these days and she had arranged with the visitor to cash a check for her at a local bank. Mrs. G. cut our visit short because she had to meet her friend. [We found this] remarkable because, until now, Mrs. G. couldn't relate [to people] at all."

On visit No. 12 Mrs. G. confided to the visitors that "Bob and Ruth (her children) live far away. I can't recall when I last saw them." Mrs. G.'s self-report on her health on this visit was that she was again suffering "just from old age."

Discussion. Low MSQ, high MSS, and poor health will probably lead Mrs. G. to a succession of crises and further deterioration in an environment with which she cannot cope.

Case No. 22. Low MSQ (5) and high MSS (26), with other problems. Mrs. S., 80 years old and a polio victim from birth, lives with her peer-age friend, Mrs. A., in a three-room apartment in New York City's Upper West Side. As in other houses in the neighborhood, the fear of being molested keeps these women behind triple-locked doors which are not opened "unless [they] recognize the voice."

Mrs. S. has a son who, she says, is "good to me and comes, if possible, every Sunday."

On the first visit Mrs. S. wept most of the time as she related stories of her childhood, her happy marriage, and her good friend, Mrs. A. (Mrs. A., 85 years old, weighs 77 pounds, has a heart ailment, and "baby-sits" for Mrs. S.) Mrs. S. is legally blind so "there's not much I can do but sit here and pray," she says. "If it were not for my faith in God," she added, "I would have jumped out of that window before now. I get so lonely; if it were not for my good friend, Mrs. A. . . ." Before the visit was over, Mrs. S. had repeated her stories several times and seemed unaware that she had told them before.

During the course of visiting a dramatic change took place in the personal appearance of both Mrs. S. and Mrs. A. and in their physical surroundings. The apartment went from "bare, dark and dreary" to "shining, cheery and cool with floor waxed, curtains hung and two lamps and a fan added," according to the visitor's report. The personal grooming changed from fairly well-groomed to very well-groomed, with jewelry and at times hair curled. Not only did the ladies dress up for the visitors, but after a few visits they served refreshments and would not let the visitors help clean up because, as they said, they did not want to "shorten the visit" and "we'll have something to do when the visit is over."

There was a marked change in the mental attitude of both Mrs. A. and Mrs. S. The early visits found them rather disinterested in "the world outside" and without "any favorite TV programs." In time the news was discussed and the visitors were reminded when "Pearl Bailey was on." There was no weeping and repetition of events. One admonition was given to the visitors at the end of each visit: "Be sure to come back."

However, on visit no. 6 the visitors found Mrs. S. confused and anxious. No doubt her physical handicaps of poor vision and lameness contribute to the helplessness that appears to be a predominating factor in her behavior. On this visit Mrs. S. suffered a loss of memory, not knowing where she was or who the visitors were. For the first time since the program began, Mrs. S. repeated stories of her overly protected childhood. The visitors contacted Mrs. S.'s son, who came to take her to his home for a few days.

Shortly after the Friendly Visitor Program ended, a Community Volunteer Visitor continued the visits. Reports of the visitor are dotted with instances of Mrs. S's signs of anxiety and need for attention.

Discussion. Low MSQ and high total MSS indicate presence of both types of mental disorder. These could render Mrs. S. unable to cope alone with her social environment. Fortunately, she is visited regularly by one of our backup visitors.

The last two cases serve as illustrations of persons who seem to be getting along. In one case, that of Mrs. F., despite a high MSS count, indicative of functional mental disorder, she seems to be getting along.

The case of Miss S. is one of a prefectly normal individual who is doing well except for her social isolation, which reflects itself in her statements about being lonely.

Case No. 13. High MSS (66) and high MSQ (8), without other problems. Mrs. F., age 83, was married for 53 years She has been widowed for the last five years. She came from a family of nine children but she herself had only two. She keeps in touch with her daughter by phone but has seen none of her family for about 15 years. She does have one friend who visits her regularly.

She has "no problems" as she says herself because "my daughter takes care of everything." In fact, she asked her daughter's permission before she allowed the friendly visitor to return to visit her.

On the first visit, the visitor's report describes what on first sight would appear to be a self-sufficient, nonisolate. The report reads: "Mrs. F. came from a large, close and interesting family and apparently was well-nurtured (with affectional bonds) in her earlier days and it shows. She handled a crisis well–her last living brother had just passed away this day and she evidently participated by telephone in funeral arrangements."

Not until visit No. 9 was there a noticeable change in Mrs. F. The visitors found her to be "very irritable, distracted, complaining even more than ever. She hurried up our visit."

By visit No. 11 Mrs. F. had been to the doctor and was told she had heart trouble. The visitor reported: "This frightens her and she keeps saying how well she is for her age (as if to reassure herself.)"

On visit No. 12 Mrs. F. showed annoyance at the questioning and writing necessitated by the administration of the Interview-Schedule. The report ends with the note that "Mrs. F. seemed very happy. to end visits because, as she says, 'I have my family.' "

Discussion. Despite high total symptom count, MSQ is high and she

is quite capable of handling the community environment. To what extent the functional symptoms are related to isolation is a matter for further research.

Case No. 24. Low MSS (3) and high MSQ (10), without social problems. Miss S is a black woman, 70 years of age, who spent the last six years of her life taking care of her older sister. The latter had recently died, just before the Friendly Visitor Program began. "With working, taking care of my sister and doing the household chores, I never had much time to socialize," Miss S. says, as she comments on her loneliness. "I have no relatives up North or friends, just acquaintances."

Miss S. had, as she puts it, a "happy home life in Virginia." Her father was "a good provider." Although she had had only two years of high school, she worked for a large concern for 35 years in the accounting department. She has been retired for five years, living on Social Security, a pension, and some savings.

From the very first visit, the visitors found Miss S. well-groomed and always adorned with a piece of jewelry. Her hair was often done by a hairdresser. Her apartment, too, showed that she took pride in it. On visit No. 6 she proudly showed her visitors the new lamp shade she had bought for her Chinese lamp.

Only on visit No. 11 did the visitors find Miss S. in a house dress and hair curlers but by this time in the program she felt, as they put it, "very relaxed and warm with us."

It took several visits before Miss S. talked about her hypertension and anxieties; prior to this she said she had "no health problems." Moreover, only later in the program did Miss S. speak of her deceased sister tearfully and how "lonely I am without her."

The visitors noted that it was on visit No. 12, their last, that Miss S. took them into her confidence and told them about her savings and "bank account received on the death of her sister."

Discussion. A normal elderly woman with few social problems outside of the one she was selected for: namely, social isolation. Her problems might simply be resolved by continued visiting. Other, similar case reports have caused those in the TC-FVP to make a concerted effort to link our program with community hospitals willing and able to provide medical as well as multiple services to the elderly residing in the community.

The sample was too small to allow any definitive conclusions about the impact of the TC-FVP program in particular and friendly visiting programs in general. However, the presence of visitors does seem to have some direct, salutary effects, particularly on behavior which can be influenced by frequent visiting: namely, apartment upkeep and amount of complaining about illnesses.[24]

Implications for Treatment

Gruenberg[25] put forth the idea that community mental health programs should not necessarily aim to prevent illness but to eliminate the social breakdown syndrome (SBS): that is, the desocialization that comes with prolonged mental problems and social isolation. In a more recent paper[26] he noted that personal efforts made to deal with SBS were as successful as drugs in eliminating behavior associated with desocialization. However, he noted that "drug abuse": that is, the heavy reliance of psychiatric practitioners on tranquilizing patients, prevented them from looking into other approaches to help patients adjust to community life.

While there have been efforts on the part of community mental health centers to serve the community and preserve mental health, there is no question but that the elderly have not been served adequately by either conventional psychiatric facilities or community mental health programs. Neither drugs nor interpersonal approaches are used frequently. Mensh[27] wrote, in a review of psychiatric care for older patients in the United States, that "trends in hospitalization and mortality, the significantly less than optimal availability of community care for older patients, and the confounding of physical and psychologic illness point to selective biases in the training of mental health personnel, the study of aged psychiatric patients and the care and rehabilitation of these older individuals."

In the United States there seem to be no community psychiatry programs specifically designed for the aged. Existing programs developed to serve all groups seem to discriminate against the aged who are consistently under-represented and underserved. On the other hand, there seems some perverse fear of discriminating on behalf of the aged by providing special programs for them, a fear which does not seem to prevent the provision of special services and facilities for children.

Rosen et al.[28] described the findings of a nationwide survey of pat-

terns of utilization of psychiatric services in the United States, using statistics from the National Institute of Mental Health collected to June 1964. They found that those over 65 occupy about 30% of all public mental-hospital beds and show higher resident-patient rates than any other age group. They then turned to the "new" approaches to reducing mental-hospital populations which stress community-based psychiatric and auxiliary services for the aged.

They found that only 8% of the aged were served on an outpatient basis and only 2% of the aged were served in clinics, figures which have not changed in the past decade. While an estimated 200,000 nursing home patients had mental disorders, their care was largely custodial. Of 175 mental-health day-care facilities available in 1965, only one was designed specifically for the aged. While 105 day-care facilities accepted older patients, only about 200 persons aged over 65 were served by them in this country. Only 9% (19,000) of private-physician's office patients were over 65. Married old people were less likely to be institutionalized. There were marked differences in the care of those between 65 and 75 and those over 75. Those in the first group were treated; those in the second receive custodial care. More recent National Institutes of Health figures collected by Kramer[29] support the findings cited above.

In the United States, 95% of the elderly reside in the community and only 5% are in institutions. Unavailability of and fragmentation of community services contributes to the stresses experienced by the noninstitutionalized elderly. In urban areas they must constantly confront cold and impersonal bureaucratic organizations as they wander from agency to agency to claim their benefits. Reluctant to use unsafe public transportation systems or venture into dangerous neighborhoods, many do not ever claim benefits to which they are entitled. Benefits such as Medicare cards, food stamps, and Social Security payments do not arrive automatically in the mail on one's 65th birthday, as is the case in Sweden, for example. Many states report millions of dollars in unclaimed Social Security funds. There are no centrally located offices for the aged to which an aged person may go to claim the benefits to which he is legally entitled, as well as other geriatric services. In rural areas, lack of transportation and the high cost of private systems are the deterrents.

Community psychiatric facilities designed to assist the aged prob-

ably should be expected to help reduce social stresses which force old people into institutions and should aim to support the aged in their communities. Not only would this approach help avoid crisis but it would prevent relocation, a stress which is fatal for many aged persons. Thus far there is little evidence that community programs designed for the aged or for all groups have addressed themselves to reducing environmental stress.

Types of Treatment to be offered the Elderly

It is not clear from published materials cited earlier what sorts of treatments are offered the elderly in community psychiatric or conventional facilities. Our case studies indicate the need for a wide spectrum of treatments including:

1) Psychotherapy, such as Butler's life-review process.[30] This is an example of treatment designed to deal with the identity crisis of old age.

2) Isolation-reducing programs such as those our staff has been experimenting with, which include: 1) Dr. Marcella Weiner's[31] group organization of old people wherever they congregate: e.g., in clinics or centers; 2) the TC-FVP, just discussed, conducted in the community; and 3) Dr. Fran Arje's[32] remotivation programs aimed at improving awareness of what the environment offers.

3) Milieu changes, specifically relocating those who cannot cope with complex environments.

4) Crisis-prevention techniques, which may include isolation-reducing programs.

Summary and Conclusions

It is necessary but difficult to summarize what I have said about social isolation, its consequences and the programs which may possibly combat it. We, as well as others, have located extremely isolated aged persons who reside in the community. We estimate that about one third of the elderly in New York City fall into this group. However, we shall have a more accurate count from our present study of the community-based aged in New York and London.[33] In the past our findings indicated that social isolation has a negative impact on the aged: it desocializes them, hampers social adjustment, and seems to reduce attitudinal independence. Isolation in the aged does not seem

to be correlated with age, sex, mental status, or education. It is not synonymous with mental disorder, although it may result in some behavior patterns associated with mental disorder, specifically poor social adjustment and cognitive functioning. If not compensated for in time, the effects of isolation may lead to serious and possibly irreversible cognitive and other impairments. However, unlike senile mental disorders, the effects of isolation may be reversible through resocialization programs, such as friendly visiting, which are presently being developed for systematic evaluation.

Until social isolation and other social stresses and problems concomitant with aging no longer exist, many of the aged probably will be at risk of developing physical, behavioral, and emotional disabilities which may have little if anything to do with the aging process per se and much to do with rejection and neglect.

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REFERENCES

1. Bourg, C. J.: *Aging: Role, Rolelessness and Relations.* Research grant AA-4-69-101-01, Administration on Aging, U.S. Department of Health, Education, and Welfare, Washington, D.C., ca. 1971.
2. UN Secretary General: *Question of the Elderly and the Aged.* Twenty-sixth session, United Nations General Assembly. Item 55 of the provisional agenda, 1971.
3. Kay, D. W., Beamish, P., and Roth, M.: Old age: Mental disorders in Newcastle-Upon-Tyne. *Brit. J. Psych. 110:* 146, 1964.
4. Bennett, R. and Eckman, J.: Attitudes Toward Aging: A Critical Examination of Recent Literature and Implications for Future Research. In: *The Psychology of Adult Development and Aging,* Eisdorfer, C. and Lawton, M., editors. Washington, D.C., Amer. Psychol. Ass., 1973, pp. 575-97.
5. Britton, J. H.: Change in adjustment of older community residents after six years. *Sixth Int. Cong. Gerontology,* Copenhagen, 1963; Youmans, E. G.: Orientations to old age. *Gerontologist 8:* 153, 1968; Rosow, I.: *Social Integration of the Aged.* New York, Free Press, 1967; Messer, M.: Possibility of an age-concentrated environment becoming a normative system. *Gerontologist 17:*247, 1967; Schooler, K. K.: The relation between characteristics of residential environment. *Seventh Int. Cong. Gerentology,* Washington, D.C., 1969.
6. Tec, N. and Granick, R.: Social problems and difficulties in social interaction in residents of a home for the aged. *Soc. Problems 7:*226, 1959.
7. Granick, R.: *Social Isolation, Socialization and Social Adjustment in Residents of Home for the Aged.* Unpublished Ph.D. thesis. New York, Columbia University, 1962.
8. Ibid.
9. Granick, R. and Nahemow, L. D.: Preadmission Isolation as a Factor in Adjustment to an Old Age Home. In: *Psychopathology of Aging,* Hoch, P. and Zubin, J., editors. New York, Grune

and Stratton, 1961, pp. 285-302.
10. Bennett, R. and Nahemow, L.: A two year follow-up study of the process of social adjustment in residents of a home for aged. *Ann. Meeting Gerontological Soc.*, Los Angeles, November 1965.
11. Bennett, R. and Nahemow, L.: The Relations Between Social Isolation, Socialization and Adjustment in Residents of a Home for Aged. In: *Mental Impairment in the Aged,* Lawton, M. P., editor. Philadelphia, Jacob, 1965, pp. 90-108.
12. Granick, R.: op. cit.
13. Walton, H., Bennett, R. G., and Nahemow, L.: Psychiatric illness and adjustment in a home for aged. *Ann. N. Y. Acad. Sci. 105*:897, 1964; Walton, H. J., Bennett, R., and Nahemow, L.: The significance of psychiatric symptomatology for social adaptation. *Brit. J. Psychiat. 110*:544, 1964.
14. Weinstock, C. and Bennett, R.: From "waiting on the list" to becoming a "newcomer" and an "oldtimer" in a home for the aged: Two studies of socialization and its impact upon cognitive functioning. *Aging Human Devel. 2*:48, 1971.
15. Ibid.
16. Ibid.
17. Ibid.
18. Nahemow, L.: *Social Integration, Persuasibility and Conformity in Residents of a Home for Aged.* Unpublished thesis, Columbia University, 1963; Nahemow, L. and Bennett, R.: Conformity, persuasibility and counternormative persuasion. *Sociometry 30*:14, 1967.
19. Mensh, I. N.: Studies of older psychiatric patients. *Gerontologist 3*:100, 1963; Bennett, R.: Community mental health programs with specific reference to those aimed at the aged. *Inst. Geront. Soc.*, Asheville, N.C., August 1971; Mensh, I. N.: Community Mental Health and Other Health Services for the Aged. In: *The Psychology of Adult Development and Aging*, Eisdorfer, C. and Lawton, M., P., editors. Washington, D.C., Amer. Psychol. Ass., 1973, pp. 529-71.
20. Mitchell, D. L. and Goldfarb, A. I.: Psychological needs of the aged patients at home. *Amer. J. Public Health 56:* 1716, 1966.
21. Mulligan, M. A., Sr.: *The Development of a Friendly Visitor Program.* Unpublished thesis, Teachers College, Columbia University, 1973.
22. Spitzer, R. L., Fleiss, J. L., Endicott, J., and Cohen, J.: Mental status schedule. *Arch. Gen. Psychiat. 16*:479, 1967.
23. Goldfarb, A. I.: Depression, brain damage and chronic illness of the aged: Psychiatric diagnosis and treatment. *J. Chronic Dis. 9*:220, 1959.
24. Harris, A.: Term paper submitted to author.
25. Gruenberg, E. M., Snow, H. B., and Bennett, C. L.: Preventing the social breakdown syndrome. *Soc. Psychiat. 47:* 179, 1969.
26. Gruenberg, E. M.: From practice to theory: Community mental health services and the nature of psychoses. *Lancet 1*:721, 1969.
27. Mensh, I. N., Studies of older psychiatric patients. *Gerontologist 3*:100, 1963.
28. Rosen, B. M., Anderson, T. E., and Bahn, A. K.: Psychiatric services for the aged: A nationwide survey of patterns of utilization. *J. Chron. Dis. 21:* 167, 1968.
29. Kramer, M., Taube, C. A., and Redick, R. W.: Patterns of Use of Psychiatric Facilities by the Aged: Past, Present and Future. In: *The Psychology of Adult Development and Aging,* Eisdorfer, C. and Lawton, M. P., editors. Washington, D.C., Amer. Psychol. Ass., 1973, pp. 428-528.
30. Butler, R. N.: The life review: An interpretation of reminiscence in the aged. *Psychiatry 25*:65, 1963.
31. Weiner, M.: *The Effects of a Resocialization Program on the Functioning of Isolated, Community-based Geriatric Clinic Patients.* Unpublished thesis. Teachers College, Columbia University, 1972.
32. Arje, F. B.: *Project Share: Reactions of Residents of a Home for the Aged to a Selected Remotivation Technique.* Unpublished thesis. Teachers College, Columbia University, 1973.
33. Zubin, J. and Gurland, B. J.: *Mental Disorders in the Aging in U.S. and U.K.* NIMH Grant 09191-10, Bethesda, Md., 1973.